NC DMA Pharmacy Request for Prior Approval -

Standard Drug Request Form

Recipient Information **DMA-3490**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Harvoni (Initial Request)** 9b. Is this request for a Non-Preferred Drug? ☒ Yes ☐ No
10. Strength: _____ 11. Quantity Per 30 Days: **28**
12. Length of Therapy (in days): ☒ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

Medical History:

1. ☐ Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.
   List preferred drugs failed: _____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction _____
   _____

2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
   _____

3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
   Please provider clinical information: _____

4. ☐ Age specific indications. Please give patient age and explain:
   _____
   _____

5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____

6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain:
   _____
   _____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

V.01

North Carolina Department of Health and Human Services

Division of Medical Assistance

Harvoni Prior Authorization Form

Recipient Information

1. Recipient Name: _____ 2. Recipient ID #:_____

Drug Information

3. **HARVONI** 4. **28** Per 28 Days

5. Length of Therapy (Check ONE)[1]:

___ **8 weeks** = Genotype 1 Treatment-naïve without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL

___ **First 8 weeks of 12** = Genotype 1 Treatment-naïve with or without cirrhosis

___ **First 8 weeks of 12** = Genotype 1 Treatment-experienced without cirrhosis who have failed treatment with either + Peg-IFN-alfa + RBV or an HCV protease inhibitor + Peg-IFN-alfa + RBV

___ **First 8 weeks of 24** = Genotype 1 Treatment-experienced with cirrhosis who have failed treatment with either + Peg-IFN-alfa + RBV or an HCV protease inhibitor + Peg-IFN-alfa + RBV

___ **First 8 weeks of 12** = Genotype 4 with or without cirrhosis

[1]**Approval will be for 8 weeks – a new PA is required with new HCV-RNA lab values to continue therapy for treatment plans greater than 8 weeks**

Clinical Information

1. The patient readiness to treat form is filled out and signed by the patient: YES or NO (circle one)*

2. The Child-Pugh Grade is: _____ (see Hepatitis-C Clinical Criteria)

3. The Genotype is: _____*

4. HCV-RNA (IU/ML) _____ and/or log10 value _____ (must be within last 6 months)*

5. Fibrosis stage _____ (see Hepatitis-C Clinical Criteria)*

***Readiness to treat form and actual lab test results (NOT PROGRESS NOTES) MUST be attached to the PA to be approved.**

6. For **Genotype 1**: Patient has tried and failed Viekira Pak: YES or NO (Circle One)

7. IF NO –

a. Does the patient have one of the following conditions in which ribavirin should not be used? (CIRCLE all that apply – Documentation is required for all indicated conditions)

- ☐ The patient has had a known hypersensitivity reaction to ribavirin in the past (e.g., Steven-Johnsons syndrome, toxic epidermal necrolysis, or erythema muliforme)
- ☐ The patient has autoimmune hepatitis
- ☐ The patient has a history of significant or unstable cardiac disease
- ☐ The patient is pregnant

- ☐ The patient has a hemoglobinopathy (e.g., thalassemia major, sickle-cell anemia)
- ☐ The patient has a pancreatitis
- ☐ The patient has been previously treated with ribavirin and had anemia related to ribavirin that necessitated stopping therapy
- ☐ The patient has a calculated creatinine clearance (CrCl) less than 50ml/min and greater than or equal to 30ml/min
- ☐ The patient is taking didanosine OR azathioprine which is contraindicated with ribavirin
- ☐ None of the Above

b. Is the patient currently taking ONE of the following medications contraindicated in Viekira Pak: (Documentation in the form of chart notes, prescription claim records, or prescription receipts required)

- ☐ Sustiva (efavirenz tablets and capsules)
- ☐ Atripla (efavirenz/emtricitabine/tenofovir disoproxil fumarate tablets)
- ☐ Kaletra (lopinavir/ritonavir tablets, capsules, oral solution)
- ☐ Ethinyl estradiol containing oral contraceptives
- ☐ Chronic sildenafil therapy for pulmonary arterial hypertension
- ☐ Prezista (darunavir tablets/suspension)
- ☐ Edurant (rilpivirine tablets)
- ☐ Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate tablets) ☐ Uroxatral (alfuzosin tablets)
- ☐ Anticonvulsants (specifically carbamazepine, phenytoin, phenobarbital) ☐ Lopid (gemfibrozil tablets)
- ☐ Rifampin
- ☐ Ergot Derivatives (specifically ergotamine, dihydroergotamine, ergonovine, methylergonovine) ☐ Orap (pimozide tablet)
- ☐ Zocor (simvastatin)
- ☐ Mevacor (lovastatin)

c. Does the patient have a Child-Pugh Grade of B or C? Yes or No

Fax all forms and lab work to CSC at: (855) 710-1969. The Standard Drug Request Form **MUST** be the first page faxed - Pharmacy PA Call Center: (866) 246-8505